PARENTAL INSTRUCTION CONCERNING MEDICAL TREATMENT

Wrestler's Name _____ Date of Birth_____

Parent/Guardian Name_____

Address_____

Telephone Numbers: Home: _____Work_____

Cell_____

Name of High School or College_____

Please indicate another person to contact in the event of any accident and we are unable to reach you. Name_____Phone_____

Insurance Company_____

Policy Number_____

Is your child presently on medication?_____ If yes, please list medication(s)_____

_____

Drug Sensitivities_____

Other Allergies_____

Please read the statements below and sign under the one that you choose. Do not sign more than one!

1. If my child needs medical attention, it is my wish that I am contacted before any medical procedures are done on my child unless immediate treatment is necessary to save my child's life or to prevent permanent injury. I accept responsibility for all cost related to such treatment.

2. If my child needs medical treatment while participating, it is my wish that the treatment be begun while efforts are being made to contact me. So that treatment is not delayed, I consent to any medical procedures that the physician believes needed, on the understanding that efforts will continue to be made to contact me.

I accept responsibility for all cost related to such treatment.

_____ _____Date_____

SIGNATURE OF PARENT/GUARDIAN (if under 21 years of age)